GENERAL RECIPROCAL CONSENT TO RELEASE AND SHARE INFORMATION (*Page 1*)

State Form 51675 (R2 / 2-05) / BCD 0108
Indiana Family and Social Services Administration
Maternal Child Health Services / Hoosier Healthwise
First Steps Early Intervention System / Children's Special Health Care Services (CSHCS)

Reset Form

First Steps
Indiana Children's Special Health Care Services

Please review the information on page 2 of this form, and have your Intake/Service Coordinator discuss any questions that you may have before signing below.

I/We_____ give my/our informed consent for:
(*Name(s) of parent/legal guardian*)

Name	Telephone	Fax number
	( )	( )

Name of agency (*if applicable*)	Address (*number and street, post office box*)

City/Town	State	ZIP code

to communicate and to share information, in writing and conversation, with the First Steps Early Intervention System and Children's Special Health Care Services regarding:

Legal name of child	Date of birth (*month, day, year*)

Address (*number and street, post office box*)	County

City/Town	State	ZIP code

The consent includes the following types of information and activities: (*as checked* ✓)

☐ Access to the early intervention record information (*including obtaining copies of written specialty reports, the IFSP, progress reports and other communications*) required to determine eligibility, participate in service planning, and/or provide early intervention services as defined in the Individualized Family Service Plan (IFSP).

☐ Other: _____

I HAVE READ AND UNDERSTAND THE CONDITIONS OF THIS RELEASE, AS CONTAINED ON PAGE 2 OF THIS FORM.

Signature of parent/legal guardian/surrogate parent	Date (*month, day, year*)

Signature of parent/legal guardian/surrogate parent	Date (*month, day, year*)

Signature of witness	Date (*month, day, year*)

Please read this carefully before signing. If you have questions, please ask your Intake or Service Coordinator.

The purpose of this release is to collect information necessary to determine my child's eligibility for the programs listed above, and to plan and provide essential and necessary services as determined through the multidisciplinary team process. I hereby authorize the person named on the reverse side of this form to release to the staff of First Steps and/or Children's Special Health Care Services upon presentation of this form, any records or information pertinent to the development and implementation of a plan for service to meet the medical, educational, developmental, social and rehabilitative needs for the child named on this release.

I also give consent for the release of information by First Steps and/or Children's Special Health Care Services to accomplish referrals for service to other individuals where an informed, written consent has been obtained from me; and to ensure ongoing service delivery in accordance with the IFSP through routine communications including report distribution, participation in IFSP meetings, planning and review activities.

I understand that this consent includes the sharing of information as authorized above in written, verbal and/or video format. This consent is effective for a period up to twelve (12) months from the date of my signature on this release. As the parent/legal guardian or surrogate parent, I understand that I may revise or revoke this release of information/consent to communicate at any point in time through the Service Coordinator indicated on the current IFSP.

The information collected as a result of this consent shall be maintained in my child's record which will be located at the System Point of Entry for the First Steps Early Intervention System and/or CSHCS, the Indiana State Department of Health. This record is subject to the provisions of the Family Educational Rights and Privacy Act (FERPA) and, as such, is available for my review and may be reproduced or corrected upon my request. All personal information collected will be treated as confidential pursuant to I.C. 4-1-6 et seq., I.C. 5-14-3-4 and 410 IAC 3.2-10.